1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10820

CERTIFICATE OF DEATH

10821
351
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Martin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sadie — Middle: B. — Last: Armstrong

4. DATE OF DEATH: Month: Oct — Day: 17 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 12, 1890

9. AGE (In years last birthday): 66 yrs. 6 mos. 5 ds.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sid Haywood

14. MOTHER'S MAIDEN NAME: Sally Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-05-0337

17. INFORMANT: Mrs. Doris Ayers — Address: 2031 Ellsworth ave, Phila 46 Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

199.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/27, 1956 to 10/17, 1956, that I last saw the deceased alive on 10/16, 1956, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas L. Jones, M.D.
ADDRESS (Street, city or town, state): Snow Hill, Md.
DATE SIGNED: 10/19/56
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 21 1956

22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Methodist

22d. LOCATION (City, town, or county) (State): Snow Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas E. Dennis — ADDRESS: Snow Hill Md.

24a. REC'D BY REGISTRAR DATE: 10-19-1956

24b. REGISTRAR'S SIGNATURE: Floyd Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10822

CERTIFICATE OF DEATH

10821

Reg. Dist. No. 3 v 3

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Kate Middle Williams Last Beauchamp
4. DATE OF DEATH Month Oct. Day 11 Year 1956
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH May 4, 1878
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME King Williams
14. MOTHER'S MAIDEN NAME Cordelia Hamblin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Margaret James Address Selbyville, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema. — INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive cardiac failure — 8 years
DUE TO
(c) Hypertensive C-V disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1953 to Oct. 1956 that I last saw the deceased alive on Oct. 4 1956, and that death occurred at 11:45 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Robert G. Grubb M.D. ADDRESS (Street, city or town, state) BERLIN, MD. DATE SIGNED 10-13-56
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/14/56
22c. NAME OF CEMETERY OR CREMATORY Odd Fellows
22d. LOCATION (City, town, or county) Bishopville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson ADDRESS Pocomoke City, Md
24a. REC'D BY REGISTRAR DATE 10/13/56
24b. REGISTRAR'S SIGNATURE Hilda Bergey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10822

10823

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 24 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Willie Middle D. Last Coaston

4. DATE OF DEATH Month Oct Day 7 Year 1956

5. SEX Female

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH March 31 - 1870

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Daniel Dixon

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs Libbie Coaston Address Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cachexia & Inanition — INTERVAL BETWEEN ONSET AND DEATH 2 mos.
DUE TO (b) Uterine Carcinoma — 1 yr.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

174.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pt. Had Epilepsy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, 19__, to Oct 7, 1956, that I last saw the deceased alive on Oct 6, 1956, and that death occurred at 12 M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN M.D. — ADDRESS (Street, city or town, state) 104 Bay St — DATE SIGNED 10/8/56

PHYSICIAN'S NAME (Type) Robert C. La Mar, M. D. — Snow Hill Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 9/56

22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery

22d. LOCATION (City, town, or county) Snow Hill (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Wayland Timms — ADDRESS Snow Hill, Md

24a. REC'D BY REGISTRAR DATE 10 1956

24b. REGISTRAR'S SIGNATURE Elwyn Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10823 **CERTIFICATE OF DEATH** 10824 53

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XXXXX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop RFD
d. STREET ADDRESS: XXXXX
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First John; Middle; Last Daye
4. DATE OF DEATH: Month Oct; Day 9; Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 6, 1894
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Jerry Myer Daye
14. MOTHER'S MAIDEN NAME: Ida Bunting
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): World War # I
16. SOCIAL SECURITY NO.: 221-18-8283
17. INFORMANT: Mrs. Pearl Daye — Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	15-30 min
DUE TO (b)	Coronary Arteriosclerosis	3 yrs
DUE TO (c)	Coronary Sclerosis	5 yrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of Bladder - No visible metastasis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 52 to Oct 9, 56 that I last saw the deceased alive on Oct 9, 1956, and that death occurred at 2:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herman A Robbins M.D. ADDRESS (Street, city or town, state): Berlin, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): Herman A Robbins M.D. Berlin, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 11 1956
22c. NAME OF CEMETERY OR CREMATORY: I. O. O. F
22d. LOCATION (City, town, or county) (State): Bishopville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Lillyville Md.

24a. REC'D BY REGISTRAR DATE: OCT 15 1956
24b. REGISTRAR'S SIGNATURE: Helen Bunting

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10824 10825

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City
c. LENGTH OF STAY IN 1b 80 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 50

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City
d. STREET ADDRESS Route 50
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First ANNIE Middle Kate Last GRIFFIN

4. DATE OF DEATH Month Oct Day 11 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct. 4, 1874
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Ocean City MD (RFD) USA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME LAMBERT BRITTINGHAM
14. MOTHER'S MAIDEN NAME ELLEN TIMMONS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Acute — INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes
420.1
DUE TO (b) Coronary Sclerosis - Arterio-sclerotic CVD — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described obave, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE F. Townsend, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. J. TOWNSEND, JR.
DATE SIGNED Oct 11, 56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/14/56
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN
22d. LOCATION (City, town, or county) BERLIN (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE 10-15-56
24b. REGISTRAR'S SIGNATURE Wm F Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10825 10826

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 63 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Angie Middle Back Lost Howard
4. DATE OF DEATH Month Oct. Day 12 Year 1956
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Feb. 12 — 1874
9. AGE (In years last birthday) 83 10 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Whitefield md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Blades
14. MOTHER'S MAIDEN NAME Virginia Sterling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17 INFORMANT Address Miss Lillie Howard Snow Hill, md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia & Emaciation — INTERVAL BETWEEN ONSET AND DEATH 2 days
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 1 year
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Cerebral Vascular Accident — 2 wks ago
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 10, 1956, to Oct 12, 1956, that I last saw the deceased alive on Oct 12, 1956, and that death occurred at 2:05 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Robert C La Mar M.D.
ADDRESS (Street, city or town, state) 104 Bay St
DATE SIGNED 10-12-56
PHYSICIAN'S NAME (Type) ROBERT C. LA MAR, M.D. Snow Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 14 56
22c. NAME OF CEMETERY OR CREMATORY Whatcoat Cemetery
22d. LOCATION (City, town, or county) Snow Hill (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Elley Timmons ADDRESS Snow Hill md
24a. REC'D BY REGISTRAR DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10820 Death Occurred 10-30-56 at

Reg. Dist. No. 11922

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill-Rural
c. LENGTH OF STAY IN 1b 7 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ohio b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF DECEASED (Type or print) First Frank Middle Joseph Last Mackun

4. DATE OF DEATH Month Oct Day 30th Year 1956

5. SEX M | 6. COLOR OR RACE W | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH 8/16/25 | 9. AGE (In years last birthday) 31 yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corp | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Ohio | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ("Name of deceased was legally changed") Frank Joseph Mackowiak | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) Dates Unk | 16. SOCIAL SECURITY NO. | 17. INFORMANT James R. Farrow Address M.A. Shore Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries—Multiple Extremes — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Plane Crash

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour 6:22 p.m. Month, Day, Year 10/30 1956 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marshes | 20f. (City or town) Near Snow Hill (County) Worcester (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE N. E. Sartorius M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) N. E. Sartorius

DATE SIGNED 11/1/56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-6-56 | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. | 22d. LOCATION (City, town, or county) Fort Myer, Virginia (State)

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Derry & Twiford, Inc. 1920 Colley Ave., Norfolk, Va. | 24a. REC'D BY REGISTRAR DATE 11-1-56 | 24b. REGISTRAR'S SIGNATURE Alwyn Cooper

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

. Two for One , et

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10827

10818

Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City Md.
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 506 - 4th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Annie Middle: Lucretia Last: Marshall

4. DATE OF DEATH: Month: Oct Day: 20 Year: 1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Apr 2nd 1874
9. AGE (In years last birthday): 82 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm T. Bloxom Sr.
14. MOTHER'S MAIDEN NAME: Emma Margaret Dix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Name, address): Mrs Lilly Taylor (Sister) Pocomoke City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): X
DUE TO (b): Multiple Sclerosis
DUE TO (c): 12
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Pocomoke City (County): Worcester (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius Sr. M.D.
EXAMINER'S NAME (Type): N E Sartorius
CHIEF MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 10/20/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 22 1956
22c. NAME OF CEMETERY OR CREMATORY: Downing Cemetery
22d. LOCATION (City, town, or county): Oak Hall (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Henry L. Wilson Pocomoke Md
24a. REC'D BY REGISTRAR DATE: OCT 22 1956
24b. REGISTRAR'S SIGNATURE: L. White

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 1 and 18. Give Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11926

10827 CERTIFICATE OF DEATH Reg. Dist. No. 355

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH
COUNTY Worcester MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Worcester.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ocean City.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) EDWARD (Middle) MARSHALL (Last) SCOTT SR.

4. DATE OF DEATH: (Month) Oct. (Day) 14 (Year) 1956

5. SEX: M.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: FEB 16, 1874

9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR, Months: Days: IF UNDER 24 HRS., Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ICELAND OWNER

10B. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS

11. BIRTHPLACE (State or foreign country): NEWARK MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE SCOTT

14. MOTHER'S MAIDEN NAME: HESTER SMITH.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): N6

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. WILLIAM H. SCOTT, BERLIN, MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebrovascular arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: 10 months

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) generalized arteriosclerotic C.V.D. — 5 years.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. ..., 1951, to Oct. 14, 1956, that I last saw the deceased alive on Oct. 14 ..., 1956, and that death occurred at 12 A M, from the causes and on the date stated above.

SIGNATURE J. Townsend Jr M.D. ADDRESS Ocean City, Md DATE SIGNED Nov 13 56.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

DATE THEREOF: 11/12/56

NAME OF CEMETERY OR CREMATORY: ST. PAULS

LOCATION (City, town, or county) (State): BERLIN MD

DATE REC'D BY LOCAL REGISTRAR: Nov. 14, 1956

REGISTRAR'S SIGNATURE: Helen F. Hayward

24. FUNERAL DIRECTOR: Jones A. Burbage ADDRESS: Berlin Md

Filed G. 206- 11/14/56 - For issuance of certificate.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10828

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10828

Reg. Dist. No. 35

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOAN Middle CAROLYN Last SMITH
4. DATE OF DEATH: Month OCT. Day 27 Year 1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 27, 1944
9. AGE (In years last birthday): 12 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: N.
11. BIRTHPLACE (State or foreign country): SALISBURY MD
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: OTIS E. SMITH
14. MOTHER'S MAIDEN NAME: BEULAH LITTLETON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Address: MR. ROLAND SMITH BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Burns Wounds - Entire Body — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO (b): 2-3° Degree & Charring.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Benzene can exploded while lighting stove in
20c. TIME OF INJURY: Hour 7 a. m. p. m. Month, Day, Year 10/27/56
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Berlin RFD #1 Worcester, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A. Rabkin M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/29/56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/31/56
22c. NAME OF CEMETERY OR CREMATORY: NEW HOPE
22d. LOCATION (City, town, or county) (State): NEW HOPE MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna R. Burbage
ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: OCT 31 1956
24b. REGISTRAR'S SIGNATURE: Helen L. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (Page) 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10819

CERTIFICATE OF DEATH

10829

Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 406 Dudley Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: 406 Dudley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SOLOMON — Middle C. — Last WHITBECK

4. DATE OF DEATH: Month October — Day 10, — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 20, 1870

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Albany, N. Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thaddeus Whitbeck

14. MOTHER'S MAIDEN NAME: Mary Carmen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 112-20-1898A

17. INFORMANT — Address: Minnie Y. Whitbeck, Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Degenerative Heart Disease — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fell several weeks before. Had Massive Hematoma Lt. Hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1950 to Oct. 10, 1956 that I last saw the deceased alive on Oct 10, 1956, and that death occurred at 2:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles W. Trader M.D. — ADDRESS (Street, city or town, state): Pocomoke City, Md. — DATE SIGNED: 10-12-56

PHYSICIAN'S NAME (Type): Charles W. Trader, M. D. — Pocomoke, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/12/56

22c. NAME OF CEMETERY OR CREMATORY: Bethany Methodist

22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: OCT 15 1956

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55